Send your letters to the Editor, British Dental Journal, 64 Wimpole Street, London W1G 8YS
E-mail bdj@bda-dentistry.org.uk
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

A fair fee?

Sir,- Following the discussion regarding the GDC annual retention fee (ARF), I would like to add my perspective as a qualified orthodontist in relation to the annual specialist list fee (ASLF), which may be of interest. In 1999 I paid £250 to be listed as a specialist and have paid the ASLF in addition to the ARF since then.

I will be working in Australia from February 2003 onwards and decided not to pay the ASLF of £200, (as it is not required to practice as a specialist). Having despatched my cheque for £300 (ARF) to work in the UK for January, I was surprised to receive a curt letter from the GDC informing me that I must henceforth remove the word specialist from my letter-head and practice plate or I would be contravening some regulation – fair enough, but I am prompted to make some observations.

I do not believe the GDC can justify the ASLF on grounds of extra costs, as I only receive one notification for both the ARF and ASLF and send only one cheque, and receive only one practicing certificate. No additional fee is required to register other additional qualifications, why is the specialist listing different?

The chief users/beneficiaries of specialist lists are patients and referring practitioners. For this reason it seems unfair that the cost of the specialist lists falls only on the specialist registrants.

I have recently completed consultant training, a process that has taken almost 10 years of various training appointments. The GDC has duly issued me with a certificate of completion of specialist training and registered my post-graduate degrees, but now states I am not permitted to use the title of specialist, because I have not paid the £200 ASLF. Aside from the loss in earnings and the personal toil of studying during the last ten years, I have paid over £20,000 in examination, fellowship and SAC recognised post-graduate course fees. There are a number of 'specialist' practitioners on the list with no qualification in orthodontics whatsoever, despite the fact that formal post-graduate training has been available for at least 25 years. For £200 the GDC will recognise these 'specialists', who have paid none of the costs and made none of the personal sacrifices for a proper training and who would not be recognised as specialists in any other country. Some of these practitioners are young enough for this 'transitional' inequality to prevail for the whole of my practicing life. The GDC could be accused of cynically debasing specialist status for reasons of its own revenue.

I applaud my GDP colleagues who voiced their objection to the ARF increase and would finally like to add an international perspective on the ARF and ASLF. The ARF in New South Wales is A$140 and the specialist listing is A$20. The exchange rate is $2.70 (Australian) to the pound.

So there you have it, the ASLF: unjustifiable, unfair, cynical and excessive and a good little earner for the GDC.

C. Daniels
Sydney, Australia

Antony Townsend, Chief Executive and Registrar of the GDC, responds:-

The Council understands the concerns about the £200 specialist fees. The decision was reached after a careful and thorough exercise.

The cost to the Council of the specialist list is not only maintaining the lists as indicated in the letter but also the transitional and set up costs. These have been high, in part due to the large cost of conducting appeals for the specialist lists. For this and other reasons, specialist list fees were only set for 2003.

For 2004 onwards thc Council is reviewing the specialist fee as part of a radical review of fees. For two reasons, the fees currently charged to specialists are likely to be adjusted. First, the set-up and transitional costs are now nearly completed. Second, there are currently only two fee-paying specialities. The Council is seeking the necessary legislation to ensure that all specialists pay a fee, which will spread the burden equally. This should lead to a lower fee being charged to those specialists currently paying a fee.

Dentistry - a medical specialization?

Sir,- I strongly feel that dental students, like other medical graduates, need to have a broader knowledge of medicine.

If dental students are taught basic human anatomy, physiology, pharmacology, microbiology, pathology, medicine, surgery etc, should they not also be given a basic medical degree? If one feels such a broad medical base is not necessary for dental students, then we can equally argue that direct education in other medical specialities, especially opthalmology, becomes superfluous.

Opthalmology, with its quite separate eyeball, lens, refractive error with related physics of light, photo-coagulation, topical therapy etc, appears to be a more separate and confined branch than dental medicine. But the dental field is treated quite separately.

Is it just because it has been traditionally like that? Considering the increased emphasis on quality and safety for consumers of health services, the tradition may need changing. If one fears it increases the duration of training, the same consideration may be applicable to many other medical branches.

With the increasingly stringent requirement of proper specialist training and revalidation, education and training have become a more continuous process, lasting almost to retirement in any medical field.

Dental students must first learn to consider the whole person, before they concentrate on their speciality. I see no reason why dental education should not be a specialization, like any other medical specialization, after basic medical graduation only. I feel the issue deserves further discussion.

M. D. Bhattarai
Dillbazar
Kathmandu
Nepal

Salt and periodontal disease

Sir,- With reference to the letter by Roland Kitchen (*BDJ* 2003, 194: 119) I would like to take issue with several points he raises.

Firstly does he advocate only the use of "salt scrub" techniques in the treatment of periodontal disease in his patients? If so, could it not be said that they are being misinformed regarding the most efficacious treatments for periodontal disease?

My training advocates the following treatment. Firstly, establish consistent mechanical plaque control of high standard inclusive of interproximal hygiene, followed by supragingival scaling and subgingival root suface debridement. This is supplemented by maintenance scaling and monitoring of the indicators of periodontal disease. Antibiotics can be considered in refractory cases, though in my opinion refractory periodontitis is merely the failure to maintain oral hygiene in the majority of cases.

In reference to "commercial mouthwashes" I agree with him that mostly alcohol-based mouthwashes are indeed of little or no benefit in the treatment of periodontal disease. Though it is ambiguous, I sincerely hope that chlorhexidine gluconate mouthwash is not included in this category as it is well known as the gold-standard plaque control agent with which all new products are compared. Its use in periodontal disease is not proven though its ability to control supragingival plaque in patients who are unable to attain a high standard of mechanical plaque control is supported by a wealth of evidence. In the same vein I believe salt is unable to reach a high enough concentration in the periodontal pocket to have any beneficial effect on periodontal disease.

Has he considered that the benefit he perceives could be the result of an increase in mechanical plaque control in his patients during the use of the salt-scrub technique? Should interproximal cleaning not also be suggested?

Though I have had no experience in the use of salt in treating periodontal disease, I have experienced success using the methods stated above and will hopefully continue to do so unless a body of evidence suggests that the use of salt is more effective. In today's litigious climate I would suggest that patients be informed by their dental practitioner of the most successful evidence-based treatment available.

N. S. Khoury
Bristol

Sir,- I was most interested in Dr Kitchen's comments re. the prescription of hot salt mouthwashes (HSMs) in the letters column.

For all my 33 years practicing life I have prescribed the use of HSMs both post extraction and minor oral surgery and as a palliative in cases of septic socket and pericoronitis. Patients have invariably reported benefit from their use, by way of relief of symptoms and I have never had any reports of this treatment causing any aggravation of the condition. My advice is always to retain each mouthful of HSM around the area in question for as long as it remains hot and to repeat until the entire tumblerful has been used. I describe it to patients as more of a mouth 'bath' than a mouth 'wash'. In view of the benefit which patients report from this regime, it would take very strong evidence to convince me that I should discontinue this practice.

In the same issue, I was also interested to read details Dr Simons' Domiciliary Audit entitled 'Who will provide dental care for housebound people with oral problems' (*BDJ* 2003, 194: 137). I have recently been one of a small group of GDPs who undertook a similar audit of domiciliary cases. The place of residence of the 34 audit patients in our audit were 59% nursing/care home, 32% own home, 6% sheltered housing and 3% hospital. The vast majority of the cases involved full upper and/or lower dentures (28), while only three cases were for routine examination.

One of the recommendations of the audit was: -

'In view of the recommendation that all patients should undergo an oral screen on an annual basis, the relatively small number of cases seen under a recall arrangement would suggest that this is an area that should be addressed.'

As with all patients, requests for domiciliary care should not be looked at as 'one-off' courses of treatment, but should be followed up on a routine basis.

J. Watt
Coatbridge

Violence towards NHS staff

Sir,- The stance against intimidation and aggression towards healthcare workers is to be commended[1]. Such unacceptable behaviour by members of the public is on the increase[2] and is a genuine cause for concern.

Despite the best intention of the the 'zero-tolerance' initiative to stop violence to NHS staff, how many of us or our staff would be able to adequately manage an actual or potentially aggressive situation in the workplace?

Whilst as professionals we try to avoid such confrontations, I wonder if we would all be able to cope if and when one did arise.

We owe it to ourselves to ensure that we are properly trained to recognise which patients have the potential to become aggressive and how to recognise the signs that an individual is becoming aggressive. It is also necessary to learn how to try to de-escalate a problematic situation once it has arisen and also how to break away should a healthcare worker be attacked.

In the current climate, and working in a practice where all the staff are female, this is a worrying thought. Those of us who do not feel the need for such education may feel that they at least have a duty to their staff to ensure that they are adequately prepared.

E. Barrett
Birmingham

1. Department of Health (2000). *Stopping violence against staff working in the NHS.* London, Department of Health.
2. Department of Health (2002). *2000-2001 survey of reported violent or abusive incidents, accidents involving staff and sickness absence in NHS Trusts and Health Authorities in England.* London, Department of Health.

Cracking components

Standard cross infection protocols call for through cleaning of equipment between patients.

I have noticed that my curing lights and operating lights are starting to experience crazing and cracking of plastic components, thereby making for uncleanable fissures. These items are less than a year old so heaven knows what they will look like in the future.

I wonder is it the alcohol based disinfectant sprays, or careless use of orange solvent that has done this damage, or is it something else? Perhaps fellow readers should do an audit of their plastic items to spot this sort of problem?

N. Jones
Blandford